Governance, Equity, and Health
Prospectus, 2002-2006

Team Members
Roberto Bazzani
Jean-Michel Labatut
Martha Melesse
Andrés Rius
Moussa Samb
Christina Zarowsky (Team Leader)

IDRC/CRDI
September 16, 2002

Table of Contents

List of Acronyms

CBOs	Community-Based Organizations
CIDA	Canadian International Development Agency
CIHR	Canadian Institutes of Health Research
COHRED	Council on Health Research for Development
CSPF	Corporate Strategy and Program Framework
Ecohealth PI	Ecosystems Approach to Human Health Program Initiative
ENRM	Environment and Natural Resource Management
Equinet	Equity in Health Network
GEH	Governance, Equity, and Health
GFATM	Global Fund to Fight Against AIDS, TB, and Malaria
GPG	Global Public Goods
HC	Health Canada
HR	Human Resources
ICT4D	Information and Communication Technologies for Development
IFIs	International Financial Institutions
INDEPTH	International Network of fieldsites with continuous Demographic Evaluation of Populations and Their Health
LAC	Latin America and the Caribbean
LACRO	Latin America and the Caribbean Regional Office
MapHealth	Macroeconomic and Adjustment Policies and Health
MIMAP	Micro Impacts of Macroeconomic and Adjustment Policies
MOU	Memorandum Of Understanding
NGO	Non- Governmental Organizations
ODA	Official Development Assistance
PAHO	Pan-American Health Organization
PBDD	Partnership and Business Development Division
PBR	Peacebuilding and Reconstruction Program Initiative
PI	Program Initiative
RX	Resource Expansion
SADC	Southern African Development Community
SDC	Swiss Agency for Development and Cooperation
SEE	Social and Economic Equity
SSA	Sub-Saharan Africa
TDR	Special Programme for Research and Training in Tropical Diseases
TEC	Trade, Employment, and Competitiveness Program Initiative
TEHIP	Tanzania Essential Health Interventions Project
UNF	United Nations Foundation
UNDP	United Nations Development Programme
WHO	World Health Organization

1. CONTEXT AND BACKGROUND

1.1. The Development Challenges: Governance, Equity, and Health

There is increasing recognition that accountability, transparency, and vigorous citizen participation are essential to achieving a viable society, sustainable economic growth, and equitable distribution of the benefits and risks of growth. Yet the countries of sub-Saharan Africa (SSA) and Latin America and the Caribbean (LAC) are characterized by persistent and in many cases worsening social, economic, gender, and health inequalities. Globally, the decline of Official Development Assistance which characterized the 1990s seems to be slowing. However, increasing attention to the problem of collective action for the global common good has yet to translate into significant increases of resources going to the South (Global Forum for Health Research 2001; Sagasti and Bezanson 2000). At the national level, despite the fledgling democracies in many countries, inadequate reforms together with persistent exclusion of large proportions of the population threaten both growth and social stability (Olowu 2001).

There is a growing consensus that many of the chronic problems faced by African countries relate to poor governance. In many of these countries, it has been shown that citizens lose confidence in governments that are unable to deliver basic services (Anderson 1999; Bond and Zandamela 2000; McDonald and Pape 2002; Seddon and Walton 1994; USAID 1998). In LAC, an important challenge is to support mechanisms through which vulnerable groups can effectively exercise their rights to health in an informed and proactive way. Public service provision is therefore a central entry point for research on the capacity of the state to carry out its functions and to promote citizen participation (Jenson et al 2001). To be effective, democratic forms of governance must rely on public participation, accountability, and transparency:

> *the intensifying political struggle around scarce health resources signal that equity approaches are self limiting when they place the populations concerned in a passive role, affected by inputs and reflecting outcomes. We suggest that equity related work needs to define and build a more active role for important stakeholders in health, including communities, health providers and funders, health professionals and other sectors* (Equinet 2000).

The health sector and health systems[1] are a microcosm of these challenges and dynamics. In addition, health is increasingly recognized as both an essential input and a desired outcome of economic growth. Both the UN Millennium Report (Annan 2000) and the Report of the World

[1] Health systems and the health sector are understood as the policies, activities, and institutions put in place with the primary goal of improving health. This distinguishes the health sector from critical determinants of health such as economic policies and conditions, but allows some flexibility. The World Health Report (WHO 2000) does not include education in the health sector, but education policies and programmes specifically around, for example, health promotion or HIV/AIDS are included. Water and sanitation services in very poor environments are also considered part of the public health system. See also Haddad and Zakus 2002.

Health Organization Commission on Macroeconomics and Health (WHO 2001) indicate that good health is one of peoples' highest priorities the world over and that poor health is one of the principal causes and consequences of poverty. Yet any examination of health and health care in the South reveals that the resources in these areas often fail to attain their objectives.

Examples of health policy and system failures abound. Where the disease incidence is disproportionately higher among the poor, such as the case of tuberculosis, lack of access to health services exacerbates the problem. In Eastern and Southern Africa, where HIV infection rates routinely exceed 20-30 percent and where tuberculosis (TB) is rampant, HIV/AIDS and TB control programs do not interact effectively at either policy or operational levels. Public health systems continue to be underfunded, poorly managed, and affected by "brain drain" to the North as well as the loss of large numbers of trained personnel to AIDS. Primary health workers are unable to effectively implement recommended programmes. Infected citizens face continued stigma, often leading to social exclusion, loss of lands and jobs, impoverishment of families through exclusion, and the high medical expenditures incurred in the usually short time span between clinical signs of AIDS and death. While new vaccines, treatments and interventions are needed to fight new and recurring diseases, they will not help the poor – and indeed can consume resources which might otherwise benefit them – unless policies, systems, and financial and human resources ensure that they are available, accessible, affordable, and acceptable. Concrete measures to improve participation, transparency and accountability in health service delivery can also help to deepen and strengthen democratic governance, through offering examples of effective implementation of "rule of law" and the creation of public spaces for dialogue and institutional change.

Good health is an outcome of many determinants and processes, most of which lie outside the health sector. Social inequalities, persistent poverty, an eroded public sector – and in Africa AIDS and its fellow travellers – are important and interrelated factors that contribute to persistent poor health status and aggravate social and political tensions. They cannot be tackled in isolation of each other, nor can they be mitigated without careful attention to socio-cultural, political, economic, and environmental realities as well as the bio-epidemiological situation. In addition to poor health services and public health interventions, the inadequate development and implementation of other supporting policies poses a major impediment to improved health in poor countries. In this regard, one of the key challenges is to overcome inequity in access to essential services.

In development policy and practice, greater attention is needed to issues of equity in improving the quality, quantity, and accessibility of essential services. In recent years, a number of scholarly publications have identified serious equity concerns in relation to health (Equinet 2000; R. Evans 2002; T. Evans et al 2000; Gilson and McIntyre 2000; Gilson 1998; Farmer 1999; Global Forum for Health Research 2000, 2001; Gwatkin 2000, 2001; Gwatkin and Guillot 1999; Gwatkin et al 2000; Kim et al 2000; Sanders and Werner 1997; Wagstaff 2002; WHO 2000). However, both research and action are needed to translate these concerns and recommendations into effective interventions. Gwatkin's analyses of Demographic and Health Survey databases reveals the

poorest quintiles continue to benefit the least from health interventions, even those thought "naturally" to target the poor. The Rockefeller Foundation, through its support to the Global Equity Gauge Initiative and the INDEPTH Network, has developed monitoring tools to identify and draw attention to systematic health inequalities. The World Bank has recently supported research to measure how well interventions are reaching the poor. But the "how" remains seriously under-examined – the processes, structures, and mechanisms that maintain or that might reduce inequities. GEH supported research will contribute to a deeper, action-oriented understanding of some of these mechanisms.

The United Nations Development Programme (UNDP) reports that health has an immediate impact on people's dignity, self-esteem, and productivity, and a long-term effect on increasing their ability to absorb new knowledge (UNDP 1997). In addition to offering direct health and productivity benefits, service provision is a key arena for citizen engagement, and a potential means of promoting citizenship and state legitimacy. Because disease can strike all, the health sector offers a potential space for social solidarity and possible resolution of some "collective action problems", from the local to the global levels. Research and evidence can strengthen civic engagement and can catalyze political and values-based policy action. It can also create a space and provide evidence for critical self-reflection among those already committed to values-based action for health equity and good governance.

But this research-to-policy-to-practice linkage remains insufficiently developed, in part because technical and political knowledge are not well integrated. There is mounting evidence that policy and institutional reforms not rooted in specific realities as well as technical solutions which ignore power and social dynamics have failed. In addition, without explicit attention to equity – itself a function of power and social dynamics – reforms do not benefit the poor. Individual policy makers and their senior bureaucrats change frequently. "Closing the loop" and promoting sustainable pro-poor initiatives therefore entails influencing the broader environments in which policy choices are made. Good governance, equity, and health are thus mutually reinforcing.

These ideas can be summarised in a causal web linking governance, equity and health:

1. strengthened citizen inclusion leads to an enhanced community oversight of health care provision;
2. community oversight and civic participation lead to increased transparency and accountability in health care provision;
3. transparency and accountability contribute to improving the rule of law, which itself has a positive impact on service delivery;
4. community voice and participation promote a better balance between the supply and demand for health services;
5. analysis of the impact of macroeconomic policies on the livelihoods of the poor clarifies how best to use different modes of service delivery to promote more equitable access to health services;and
6. improved design and monitoring of poverty reduction strategies mutually reinforce improved pro-poor policy making and service delivery for health.

Clearly, GEH cannot definitively prove or disprove the global validity and significance of this hypothesized causal web. It can, however, strengthen the capacity of actors at the local, national, and global levels to identify and act on many of these linkages. They can accomplish this through the entrypoint of governance and the technical challenges related to the policy process, health systems, priority diseases, and civic engagement for health and social equity [2].

GEH proposes to move beyond a statement of desirable principles and managerial techniques by drawing attention to power, actors and processes (Barker 1997; Campbell 2000; Munro et al 1999). In doing so, it promotes a contextualised approach. A recent analysis, "Evaluating Democracy and Governance Assistance" (Crawford and Kearton 2002) concluded that the almost universal emphasis on "impact" – measured through program content, structure and/or numbers of beneficiaries – cannot capture and at times fundamentally misreads the dynamic, interactive, contextual dimensions through which "governance" is ultimately "made good."

Good governance does not occur in the abstract; while principles such as fairness, transparency, and accountability may be shared across many domains and societies, they must be concretely manifest in relation to real needs in specific contexts. How such principles translate into interactions among persons and institutions is highly variable (Knight et al 2002). The general promotion of "rule of law" or elections is only a first step. Moreover, solutions to the health or poverty problems of one country cannot simply be transposed to the very different contexts and political cultures of another.

Nonetheless, there are lessons to be shared among sectors as diverse as health, education, judicial reform, and mining. These include processes such as decentralisation; mechanisms to promote the creation of public spaces for debate or transparency in budget allocation; and ways to negotiate the interests of communities, managers, policy makers, researchers, and donors. If research on governance is to make a difference to people's everyday lives, greater attention must be given to the nuts and bolts of these interactions among actors, institutions, processes, and traditions in the exercise of power and in the making and implementation of policy decisions. The GEH program is poised to undertake such work.

[2] In the context of GEH programing, governance is defined as "the institutions, processes and traditions which determine how power is exercised, how decisions are taken, and how citizens have their say" (Institute on Governance). This operational definition is congruent with the UNDP's definition of governance as "the exercise of political, economic and administrative authority to manage a nation's affairs. It is the complex mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences" (UNDP, Reconceptualising Governance, 1997).

2. GEH VISION, MISSION, AND OBJECTIVES[3]

2.1. Vision Statement

GEH's work is guided by a vision for an equitable, fair, and just provision of public services, particularly to the marginalized and excluded groups in developing countries. The GEH vision statement is articulated in detail in the box below.

GEH Vision

Communities, health service providers, policymakers, and donors share a commitment to democracy, health equity, and social justice. They work collaboratively with researchers and actively contribute to health systems which promote effective and equitable health intervention strategies. Municipal, regional, and national governments allocate resources and take policy actions related to health systems and service delivery based on concrete evidence and analysis of real needs of the poor. These decision makers manage public resources carefully and transparently because they are committed to democracy, equity, and good governance and consider efficiency to be an important tool for achieving health and social equity. Financing for public health is guided by principles of fairness and sustainability. Formerly excluded and marginalized groups have equitable access to quality health services. Citizens, particularly marginalized and under-served populations, are able to organize and can effectively present their needs to policymakers, and participate in health policy processes and program decisions at local, national, and international levels. Researchers, decision makers and communities can identify and influence actions to improve accountability, strengthen rule of law, and create public spaces for policy dialogue. They can do so because they can publicly discuss and work together to change the behaviours, practices, traditions, power relations, and channels of communication through which policy and practice choices are made and implemented. Donor practices are influenced by good evidence in support of core political and ethical goals: deepening democracy and health and social equity. The research community, governments, and citizens use lessons learned through the health sector to strengthen democracy and social equity throughout society as a whole.

2.2. Mission and Objectives

GEH's mission statement can be summed up as follows: *strengthening health systems; promoting civic engagement; and making research matter.* This translates into three general

[3] GEH has been working in collaboration with the Evaluation Unit to implement Outcome Mapping as a monitoring and evaluation system. In order to facilitate an operational monitoring of key behavioural changes in relation to our boundary partners, we have articulated a vision statement and a mission/objectives statement which are more detailed than a prospectus typically requires. These are intended to make the vision which guides our work and the objectives which constitute our core activities and targets as explicit as possible.

objectives of the program:

1. To support applied research that will both strengthen and monitor the capacity of governments to ensure equitable financing and delivery of priority public health and health care services, especially to marginalized and underserved populations;
2. To support informed and effective citizen demand and participation throughout the policy-to-practice process; and
3. To increase the effectiveness of research-to-policy linkages in promoting the dual goals of health and social equity.

More specifically, GEH aims to:

In support of Objective 1:

i) integrate political, social, economic, and policy analysis into research on public health systems and policy in order to (a) provide solid grounds for making informed and needs-based decisions on the equitable financing and functioning of health systems; and (b) examine the governance challenges critical for deepening democracy and increasing health and social equity.

ii) build a systematised body of research results and tools, available in a usable and problem-oriented format that will inform national and international policy dialogue to reinforce political commitment to support equitable access to health systems.

In support of Objective 2:

iii) facilitate collaboration among researchers, NGOs, health practitioners, community and advocacy groups, and local/municipal/national governments in order to develop strategies to improve accountability, strengthen the rule of law, and create public spaces for policy dialogue that focuses on public services for health.

iv) identify and test mechanisms that promote effective and informed participation of citizens in the policy and practice of service delivery for health at local, national, and international levels, particularly among sub-populations which are now largely excluded from access to services and from policy consultations.

In support of Objective 3:

v) systematically examine health sector reform experiences and results, in order to identify opportunities and challenges in translating lessons learned and policy recommendations on equitable access to health services among different countries and policy environments;

vi) build long-term partnerships with key like-minded actors, through linking research projects wherever possible to larger on-going development programs and through gradually building a critical mass of findings, networks, and tools around selected topical and geographic nodes.

3. APPROACH TO PROGRAMMING

The work of GEH revolves around two key axes (themes):

- The politics and processes of service delivery for health; and
- Access and its effects on health and social equity

The first axis, *politics and processes of service delivery*, indicates a relative emphasis on health policy and system governance, and addresses the *supply side* of policy making and service provision. The second, *access and its effects on health and social equity*, indicates a relative emphasis on citizen rights and engagement, thus addressing the *demand side*. Together, they represent the crux of GEH: two necessary poles in dynamic interaction. The primary emphasis of both is equity.

In order to engage both health sector and governance researchers and decision makers, GEH, in consultation with Southern partners, has identified key research areas or entrypoints through which interested actors are likely to approach GEH. Together, these cover the key elements of a participatory research-to-policy-to-practice continuum that addresses the development challenges of promoting good governance, equity, and strong health systems. Subsequent phases may either narrow or expand the focus and reach of programing. However, at the outset it is important to explore how the pieces of the puzzle fit together ("proof of concept") and where the interest, needs, and capacity lie.

Over this prospectus period, GEH will build a balanced portfolio of projects, programs and networks engaging these themes through one or more of four topical **entry points** or **research areas**:

- The policy process (e.g. formulating, implementing, and evaluating pro-poor policy for health; fair and sustainable financing; influences of donors and globalization on policy);
- Health systems (e.g. effective delivery of quality services; human resources; transparency and accountability; corruption);
- Priority conditions or interventions (such as TB, HIV as an entry points into broader governance, equity and health systems issues); and
- Civic engagement (e.g. mechanisms to promote effective and informed participation and inclusion; exercising the right to health; health and health care as an arena for democratization).

The main programing focus of GEH is at country level. However, important determinants of policy and practice within countries often lie outside the country (e.g. regional or global trade and environmental trends; donor or international financial institutions policy). The program therefore strategically and selectively engages the supranational level where this offers significant additional understanding of key problems, and/or policy levers that will improve health and social equity within the countries of the South.

Over time, GEH hopes to build a body of research and researchers who can inform action at all

levels in the countries and regions where the program is active. The initial substantive and policy-level entrypoint for research will depend on the critical bottlenecks in the country or region, and the capacity of researchers and decision makers to conduct and use GEH's transdisciplinary approach to research.

The methodological approach is characterized by linking measures of well-being with the processes by which key actors (the state, NGOs, users/citizens, the private sector) supply and demand public services for health. It is therefore inherently transdisciplinary (health systems; health economics; political sciences; anthropology; sociology; management). Most projects will address dynamic interactions and will include:

- policy and political systems analysis, addressing structures, actors and processes;
- gender analysis;
- particular attention to existence and mechanisms of inequalities (socio-economic, occupational, ethnic, gender, age - as relevant); and
- participatory approaches.

Because this is an innovative approach to health and governance research, the program expects to invest significantly in capacity building and will therefore have a balance of competitive Requests for Proposals, strategic or targeted programs and projects, and support for networks, closing the loop, synthesis, and training.

The CSPF identified Sub-Saharan Africa as the area where new governance and health systems work should focus, with a secondary focus on LAC. The health systems and research capacity challenges in SSA are particularly acute, hence justify the IDRC emphasis on this region. In LAC, there is a significant body of IDRC-supported work and researchers on which to build. However, there is no a priori reason why GEH research should be limited to these two regions: the development and research challenges are widespread, and through the Swiss Agency for Development and Cooperation (SDC) partnership we hope to facilitate the translation of lessons

Promoting Health Equity in the SADC Region and Beyond

When the Network for Equity in Health in Southern Africa (Equinet) was launched in 1998 with the IDRC support, increasing inequity in health in the Southern Africa Development Cooperation (SADC) region was a concern shared by many researchers, health practitioners, NGOs, and civil society groups. Equinet is a network of research, civil society, and health sector organizations seeking to influence health policy in Southern Africa. Its goal is to build alliances leading to effective and pro-poor health policies at both the local and regional levels. It does so by networking professionals, civil society, and policy makers to promote policies for equity in health; by undertaking research, initiating conferences, workshops, and Internet discussions; and by providing inputs at the SADC forums.

Equinet has been seminal in promoting policy reviews and public dialogue on health in the SADC region, including on issues related to globalization and macroeconomic policy; governance and rights; resource allocation; and community participation. With the financial support from IDRC/GEH, the Network has now embarked on its second phase, with greater emphasis on capacity building for policy dialogue and advocacy, and the development of a regional base for equity in health in Southern Africa. IDRC funding will support 1) coordination and operation of the Network, including its interactions with policymakers and other stakeholders; 2) a program of peer-reviewed small grants and commissioned papers relating to equity and health; and 3) state-of-the-art reviews, methods development, field studies, comparative analysis, and policy dissemination of research tools and findings in three of the priority areas: impacts of governance mechanisms and participation on integrating community preferences in planning and resource allocation; integrating deprivation measures into resource allocation mechanisms; and policy research.

among other regions, where appropriate. At the mid-term evaluation, GEH will reconsider whether a regional or a global focus is most appropriate. At the outset, however, we propose to support research teams in SSA and LAC because this will strengthen local research capacity, generate results likely to be of immediate local use, and foster "closing the loop" partnerships

among researchers, communities, and decision makers.

4. ACTIVITIES

In its first year of programing as a corporate project, GEH built on existing research platforms in both sub-Saharan Africa and LAC. These include, among others, incorporating governance and equity dimensions into the TEHIP work; strengthening the Equity and Health Network through greater emphasis on linking evidence and advocacy on equity in health in the SADC region; and developing a joint IDRC-Pan-American Health Organization project on research-to-policy linkages in LAC. These projects map onto GEH's proposed research areas: the policy process; health systems; priority diseases or conditions as an entry point into broader governance and health systems issues; and civic engagement.

The approach of building on existing work was a successful strategy for jump-starting a comprehensive program. "Building on existing work," however, must be interpreted flexibly if lengthy delays are to be avoided and if recipients are not to see this as yet another externally imposed "priority." This flexibility has been integrated in the program from the outset, and we are now in the position of having a portfolio of projects approved or under development that touch on nearly the full range of issues and levels we hope to engage over the coming years.

As the first year of programming unfolded, the objectives and strategies of GEH became more fully conceptualised and articulated, with a vision of addressing challenges common to both SSA and LAC, and building a coherent single programme. The core of GEH, however, is the dynamics through which common challenges are manifest in specific contexts. Recognition of

Monitoring Public Policies and Equitable Access to Health Care

Social exclusion, and particularly the limited access to health services by the poor and disadvantaged groups, is becoming a key concern in many developing countries. Research findings from the IDRC-supported MapHealth project suggest that macroeconomic and sectoral reforms often enlarge inequalities among populations. The reforms lead to greater access to services for better-off people (often through private services), while excluding the poor or exacerbating their situation. The research identified equity in access to basic services as one of the top priorities in the fight against poverty.

IDRC (GEH and MIMAP), in collaboration with SDC, is supporting a coherent body of projects under the MapHealth II umbrella, linked by common themes of public policy, equity, and access to health care. Université de Montréal coordinates the MapHealth II program, whose overarching goal is to enable Southern countries to amass relevant data/information for evidence-based health care reforms, with an emphasis on equity in access.

A project in West Africa,"Politiques publiques et protection contre l'exclusion", is among the first activities in the MapHealth II portfolio supported by GEH. A second, with MIMAP funding, is being developed in Kerala, India focusing on community based health monitoring system. In West Africa, research teams from Burkina Faso, Côte d'Ivoire, Mali, and Senegal, and are examining existing experience and databases on health sector reforms and modes of financing and participation, with a focus on social inclusion and gender. A team from Benin is still being developed. The ultimate goal is to launch a network of research and policy analysis with a mandate to promote equitable access to heath care in the region. At the end of this 18- month project, the Centre and the research teams will be in a position to decide whether the conditions (namely interest, capacity, feasibility) exist to create a Health Systems Observatory for West Africa.

regional and sub-regional differences in priorities and capacities is therefore integral to the programme.

The GEH program begins with a sectoral focus on health and a geographic focus on SSA and LAC. However, the framework is relevant to key questions in the management of other public goods, notably education, and to other geographic areas. As noted earlier, the program will evaluate the possibilities of expanding its substantive and geographic coverage mid-way through the prospectus period.

The strong resonance of the key elements of the GEH conceptual framework among African and LAC partners with whom we consulted confirms that there is a solid foundation for coherence among the SSA and LAC components of the program. This coherence and the synergies offered by complementary priorities and capacities will be supported in four ways:

- the development of "GEH Research Matters" in partnership with the Swiss Agency for Development and Cooperation;
- identification of common research areas and entry points for the two regions;
- selection of individual projects in both regions, in part according to how they will complement regional, thematic, and overall program development in GEH; and
- further development of the "MAPHealth II" sub-program on *public policies and equity of access,* which contains both SSA and LAC components.

In the next two years, GEH will continue to build a portfolio of projects addressing the four research entry points. At this time we are actively seeking to develop projects on the policy process and on health systems more broadly. These will complement projects that engage GEH issues from the entry point of priority conditions and others that emphasize civic engagement in the policy process. The second two years will also see GEH focussing on those research areas, teams, and locations which show the most promise for being effective levers for change in the health systems and policy and/or governance arenas. In addition, the program may expand geographically and/or thematically (to education), should resources permit.

More specifically, in year 1 of the prospectus, GEH will:

- continue to develop, support, and monitor projects in the four research areas;
- support TEHIP developing the "Duluti Lake Centre on Evidence for Health Policy";
- strengthen the networking and closing the loop dimensions of MAPHealth and Equinet;
- support the next stage in the development of the Africa Health Research Forum;
- stablish the foundations of "GEH Research Matters" (see section 4.1 below);
- develop LAC programing in collaboration with UNDP (to be launched in Year 2);
- collaborate with ICT4D to explore research on the use of ICTs for health service access, information provision, and distribution equity;
- begin to develop the Regional Funds outlined below;
- establish Outcome Mapping as a monitoring and evaluation system;
- consolidate the GEH-SDC partnership; and
- participate in the CIHR-led inter-agency Request for Proposals on Global Health Research.

A Link between Municipal Services and Public Health?

The link between municipal services and public health has emerged as a serious concern in Southern Africa. Today, the lack of adequate water, sanitation, and electricity in poor households claims the lives of hundreds of thousands of people in the region. Although this has attracted research interest for some time, most work to date has centred on the technical and managerial aspects of services delivery. Not enough attention has been given to aspects of equity or the larger political, economic, and social debates around different service delivery models. There is a need for deeper understanding of the complexities of the health-services link, including the governance issues and power relationships between citizens and the state that mitigate policy outcome.

It is against this backdrop that the Municipal Services Project (MSP) was developed as a research, policy, and educational initiative examining the restructuring of municipal services in South(ern) Africa. Work to date has focussed on the impacts of decentralization, privatization, cost recovery, and community participation in the delivery of these municipal services to the rural and urban poor.

With financial support from GEH, Phase II will examine the causal linkages between different models of municipal service delivery (i.e. public, private, community-based, NGO-delivered, and parastatal) and health in the region. It will also identify and evaluate publicly-owned and operated models of municipal service delivery which improve public health, are equity-oriented, sustainable, and accountable to those that they serve (i.e. "public-public partnerships"). Finally, it will evaluate and promote civic engagement in municipal service delivery and decision making, and aim to influence policy and public debate on municipal services and health in the region and internationally. The project will address both axes of the GEH thematic: the politics and processes of service delivery, and equitable access.

Among new initiatives planned in the short and medium term, two are worth noting here: the "GEH Research Matters" initiative, and the Regional Funds.

4.1. "GEH Research Matters": A dynamic tool to facilitate "closing the loop"

IDRC and SDC officers concluded, after discussion with their institutional colleagues and Southern partners, that it would benefit both the GEH program and the research/development communities to have an arms-length platform for critical reflection, synthesis, dissemination and rapid response on critical or emerging issues on governance and health. GEH therefore proposes to create a dynamic and lean project, tentatively named "GEH Research Matters". This will complement project and network-level "closing the loop" activities by catalyzing the synthesis and targeted dissemination of lessons learned from GEH and from other efforts in the health and governance area. The "GEH Research Matters" initiative is therefore envisaged to be a responsive and independent knowledge translation instrument within GEH.

The specific objectives of this initiative include:

- to consolidate the evidence gathered through GEH and its research partners in an accessible

and user-friendly database;
- to facilitate communication and targeted dissemination of relevant evidence to development partners, in collaboration with existing institutions and networks, the media, and other programs and divisions in IDRC and SDC;
- to respond rapidly to questions from interested development partners on critical or emerging issues, by playing a clearinghouse role for pluralistic but engaged synthesis and meta-analysis, presenting key arguments of dissenting positions where these exist but concluding with an evidence-based recommendation or position;
- to stimulate self-evaluation and critical reflection within GEH and other institutions, networks, and development programs on both the substance of their work (by identifying contested or emerging issues) and the extent to which they are succeeding in linking research with action; and
- to identify where new research might usefully contribute to filling evidence and action gaps related to governance, equity, and health, and to refer to IDRC or to existing research institutions and networks for longer term follow- up where this appears to be indicated.

A small team could manage this initiative with a budget to support data analysis and interpretation, consultancies, and meetings. As the initiative will accompany GEH during its institutional life, creating a permanent structure is not considered necessary. Rather, GEH will facilitate the institutionalisation of its core competencies within GEH-supported networks and institutions. If this should prove to be a useful contribution to "closing the loop", independent of its added value to GEH and the IDRC- SDC partnership, broader institutionalisation may be considered at a later date.

4.2. Regional Funds

During the current CSPF, GEH will initiate the creation of two regional funds and invite other donor organizations to join. These funds, one in East and Southern Africa and another in Central America, will support a training workshop and project development in each region, followed by a call for proposals. The goal of the workshops is to strengthen the capacity of Southern institutions and researchers to integrate political analysis into health systems research. This type of activity, successfully carried out by the Ecohealth PI, will contribute to capacity building in the South and lead to effective collaboration among donor organizations. It will also help GEH to build fairly rapidly a critical mass of projects in each region.

Building Health Systems Research to Policy Links in the Americas

A recent review of research on health sector reforms in LAC carried out by Pan American Health Organization (PAHO)and IDRC revealed a dearth of evaluative research, despite the wave of reforms that swept most of the countries in the region during the 1990s (Almedia, Bazzani & Pittman 2000). Today, many governments in the region are considering alternative strategies for reforms, grounded in the need to improve equitable access to quality health services and to extend social protection in health. As governments prepare to launch new health policy efforts, the perceived need for research and for policy analysis has been greatly heightened.

PAHO and IDRC have long supported research and knowledge management for better health policy decisions and their implementation in the LAC region. As an initial response to the recommendations of the IDRC-PAHO forum on health sector reform in the Americas (Montreal, April 2001), IDRC (GEH) and PAHO are jointly supporting a project on bridging research to policy and practice. In an initial phase, the project will request proposals to evaluate, ex-ante or ex-post, the following broad question: what is the impact (expected or realized) of innovative strategies to expand social protection in health? The overarching goal is to generate research and lessons for promoting equity and expanding social protection in health, that are useful to health decision makers in the region.

To this end, a Request for Proposals (RfP) will be issued that will require a joint initiative by researchers and a group of decision makers, from either a governmental sector (e.g. legislative branch, Ministry of Health, Social Security Bureau), civil society (e.g. trade unions, community based groups), or the media. The RfP will focus on innovative strategies to expand social protection in health. It will be issued through three sub-regional networks: the Southern Cone Network for Health Systems and Services Research; the Central American Health Systems and Policy Research Network; and the Caribbean Health Services and Policy Research Network.

5. PROGRAM OUTPUTS AND OUTCOMES

GEH aims to promote a better understanding of the linkages among governance, equity and health in the work of decision makers, practitioners, researchers, community-based organizations, and the donor community. In other words, GEH aims to contribute to a *shift in thinking and practice* among key actors so that political and governance challenges, equity concerns, and technical health and health policy questions are increasingly considered as integrally related.

In support of this ultimate objective, GEH activities are expected to: (i) examine the processes and outcomes in the health sector, paying particular attention to important lines of potential social cleavage such as gender, socio-economic status, and ethnicity; (ii) identify opportunities to apply the findings to other sectors; and (iii) develop a Knowledge Transfer Platform ("GEH Research Matters") to complement project- and network-level "closing the loop" activities with a meta- project dedicated to catalyzing the synthesis and targeted dissemination of lessons learned from GEH and from other efforts in the health area.

Individual projects, networks and sub-programs funded by GEH will vary in their geographic

setting and will address a range of issues relating to the governance, equity and health nexus. The balance of activities funded by the programme will collectively produce the following outputs:

- a systematized body of research results and tools, available in usable and problem-oriented format, that demonstrably contributes to national and international policy dialogue regarding equitable access to health systems;
- strengthened capacity for transferring policy-relevant knowledge through comparative studies, synthesis and dissemination of findings and tools generated by individual projects, and and linkages among researchers and decision makers at different levels;
- a record of experience with approaches and mechanisms that promote effective and informed participation of citizens in the policy and practice of service delivery for health, particularly among sub-groups which are now largely excluded from access to services and from policy consultations; and
- established research networks applying the locally relevant elements of the GEH approach in Africa and Latin America.

6. PARTNERSHIPS

GEH aims to solidify key partnerships during this prospectus period with SDC and in Canada, with CIDA, Health Canada, and CIHR through a Memorandum of Understanding (MOU) for global health research. This Canadian MOU is currently operationalized in an interagency and interinstitutional Coalition for Global Health Research and most recently in a joint Request for Proposals in Global Health Research, under the auspices of CIHR. This Coalition is a tool to push member agencies to significantly increase and improve their support for global health research, particularly for African-led research and research networks as well as for global initiatives. These initiatives include the Global Forum for Health Research, the Africa Health Research Forum, Council on Health Research for Development (COHRED), and WHO research programs such as Special Programme for Research and Training in Tropical Diseases (TDR) The Coalition also helps to strengthen research-policy linkages in the health sector with CIDA. This includes identifying entry points for GEH-supported work to inform the Global Fund to Fight Against AIDS, TB and Malaria (GFATM), on whose Board Canada, Switzerland and the UK share a seat. In addition, GEH will continue to work collaboratively with the Rockefeller Foundation's Global Health Equity Initiative; UNDP's programs on Global Public Goods and Health and Human Development in Central America; UNF (through TEHIP and potentially in other areas, including Haiti); the World Bank (through the Reaching the Poor research program, through Université de Montréal`s and CIDA's involvement in developing tools and analyses for health systems research, and through the World Bank Institute on tools arising from MAPHealth I and II), and partners who join us in the Regional Funds.

GEH has been negotiating a program-level partnership with the SDC since October 2001. This partnership builds on project-level SDC contributions to MAPHealth and discussions among

GEH, the Social Development Division of SDC, and the Unité de Santé Internationale at the Université de Montréal to continue project and network-level collaboration in MAPHealth II. In the two institutions – SDC and IDRC/GEH – there is a convergence of interest in evidence-based policymaking for equitable access to public goods and health sector reforms, and a shared concern to strengthen research-practice linkages, both in the field and among agencies. GEH and SDC therefore decided to explore a program-level partnership over four years, with SDC contributing CHF1.7 million to GEH for MAPHealth II, Equinet, GEH Research Matters, and other mutually developed projects on equity, access, and governance in the first phase of collaboration. GEH interest in Outcome Mapping further strengthens the partnership since SDC's Evaluation Unit is also initiating joint work with IDRC's Evaluation Unit on Outcome Mapping. The SDC Board approved an "entrée en matière" in May 2002, committing the CHF1.7 million, subject to SDC approval of the final terms of the partnership.

GEH supports donor partnerships based on a shared vision and in accordance with IDRC's principles of partnership. It is important to stress that the purpose of the partnerships is to contribute to achieving the GEH vision, and to promote strong linkages between research and development. GEH will therefore support, to the extent possible, research which is integrated into or has a strong development/implementation component. Our primary mission is to support the South, and not to become absorbed into donor and multilateral agency agendas. In this regard, our monitoring and evaluation plans, as well as our project selection criteria, will incorporate opportunities for direct Southern partner input on our donor partnerships.

REFERENCES CITED

ANDERSON, Jim. 1999. From Levers to Legitimacy, Governance in Transition. Ottawa: The Governance Network

ANNAN, Kofi A. 2000. We the Peoples. The Role of the United Nations in the 21st Century. New York: United Nations

BARKER, Jonathan (ed). 1999. Street-Level Democracy: Political Settings at the Margins of Global Power. Toronto and Connecticut: Between the Lines Press and Kumarian Press

BOND, P. and H. Zandamela. 2000. "Governance and Service Delivery in Eastern and Southern Africa: Issues for Debate, Directions for Research". Unpublished manuscript commissioned by IDRC for IDRC Consultative Meeting on Governance, September 7-9, 2000.

CAMPBELL, Bonnie. 2000. "An Overview of Governance". Unpublished Manuscript commissioned by IDRC for IDRC Consultative Meeting on Governance, September 7-9, 2000.

CRAWFORD, G. and I. Kearton. 2002. Evaluating Democracy and Governance Assistance. Centre for Development Studies, Institute for Politics and International Studies, University of Leeds.

EQUINET. 2000. Equity in Health in Southern Africa: Turning Values into Practice. Equinet Policy Series No. 7. Harare

EVANS, Robert. 2002. Interpreting and addressing inequalities in health: from Black to Acheson to Blair to....?. London: Office of Health Economics

EVANS, Tim, M. Whitehead, F. Diderichsen, A. Bhuiya, M. Wirth. 2001. Challenging Inequities in Health: From Ethics to Action. Oxford: Oxford University Press

GILSON, Lucy. 1998. "In defence and pursuit of equity". *Social Science and Medicine* 47(12):1891-1896

GILSON, L. and D. McIntyre. 2000. "Experiences from South Africa: Addressing the Legacy of Apartheid", in T. Evans et al (eds), Challenging Inequities in Health: From Ethics to Action, pp. 191-209. Oxford: Oxford University Press

FARMER, Paul. 1999. Infections and Inequalities. Berkeley: University of California Press

GLOBAL FORUM FOR HEALTH RESEARCH. 2000. The 10/90 Report on Health Research 2000. Geneva: Global Forum for Health Research

GLOBAL FORUM FOR HEALTH RESEARCH. 2001. Monitoring Financial Flows for Health Research. Geneva: Global Forum for Health Research

GLOBAL FORUM FOR HEALTH RESEARCH. 2002. The 10/90 Report on Health Research 2001-2002. Geneva: Global Forum for Health Research

GWATKIN, Davidson R. 2000. "Health Inequalities and the Health of the Poor: What Do We Know? What Can We Do?" *Bulletin of the World Health Organization*, vol. 78, No. 1 (January 2000): 3-17.

GWATKIN, Davidson R. 2001. "The Need for Equity-Oriented Health Sector Reforms." *International Journal of Epidemiology*, vol.30: 720-723.

GWATKIN, Davidson R. and Michel Guillot. 1999. The Burden of Disease among the Global Poor: Current Situation, Future Trends, and Implications for Strategy . Washington and Geneva: The World Bank and the Global Forum for Health Research.

GWATKIN, D., S.Rutstein, K. Johnson, R. Pande, A. Wagstaff.2000. Socioeconomic Differences in Health, Nutrition and Population. Washington, D.C.: The World Bank http://www.worldbank.org/poverty/health/datat/index.htm

HADDAD, Slim and David ZAKUS. 2002. "Promoting Canadian Involvement and Capacity Building in Global Health Policy and Systems Research: Perspectives and Recommendations". Research Paper prepared for the Institute of Population and Public Health, Canadian Institutes for Health Research. (Short version accessible at http//www.cghrc.ca/ghpsr.html)
IDRC. 2000. "Governance and Current IDRC Programming: An Overview". Internal document, September 2000

JENSON, J., J. Harvey, W. Kymlicka, A. Maioini, and E. Shragge, P. Graefe, and J-M. Fontan 2001. Building Citizenship: Governance and Service Provision in Canada. CPRN Discussion Paper No. F/17. Ottawa: Canadian Policy Rsearch Networks

KIM, Jim Yong, J.V.Millen, A. Irwin, J.Gershman (eds). 2000. Dying for Growth: Global Inequality and the Health of the Poor. Monroe ME: Common Courage Press

KNIGHT, B., H.Chigudu, R. Tandon. 2002. Reviving Democracy: Citizens at the Heart of Governance. Earthscan, Stylus Publishing, LLC

OLOWU, Dele. 2001. Decentralization Policies and Practices under Structural Adjustment and Democratization in Africa. URISD - Democracy, Governance and Human Rights, Programme Paper No. 4. Geneva: UNRISD

McDONALD, David A. and John Pape (eds). 2002. Cost Recovery and the Crisis of Service Delivery in South Africa. Cape Town and London: Human Sciences Research Council and Zed Books

MUNRO, W., V. Padayachee, F. Lund and I. Valodia. 1999. "The State in a Changing World, Plus Ça Change?: Reflections from the South on the World Bank's 1997 World Development Report." *J. International Development*, 11: 75-91

RIUS, Andres. 2000. "Innovations in the Management of Public Goods in LAC: Some thoughts on the possibilities" (Internal IDRC document)

SAGASTI, Francisco and Keith Bezanson. 2000. Financing and Providing Global Public Goods: Expectations and Prospects. Sussex: Institute for Development Studies/ Stockholm:Regeringskansliet, Ministry for Foreign Affairs

SEDDON, David and John Walton. 1994. Free Markets and Food Riots. Oxford: Basil Blackwell Publishers

UNITED NATIONS DEVELOPMENT PROGRAM. 1997. Governance for Sustainable Human Development. A UNDP Policy Statement.New York: UNDP

UNDP. 1997b. Reconceptualizing Governance. New York: UNDP

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT - Center for Democracy and Governance. 1998. Democracy and Governance, A Conceptual Framework. November 1998. Washington D.C.: USAID Technical Publications Series

VOLMINK, J., P. Matchaba and M Zwarenstein. 2001. "Reducing Mother-to-Child Transmission of HIV Infection in South Africa", in Informing Judgment: Case Studies of Health Policy and Research in Six Countries. Milbank Memorial Fund and Cochrane Collaboration, September 2001. (http//www.milbank.org/reports/2001 cochrane)

WAGSTAFF, Adam. 2002. "Poverty and Health Sector Inequalities", *Bull. World Health Organization* 80:97-105

WERNER, David and David Sanders. 1997. Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto: HealthWrights

WORLD HEALTH ORGANIZATION. 2001. Macroeconomics and Health: Investing in Health for Macroeconomic Development. Report of the Commission on Macroeconomics and Health. Geneva: WHO

WORLD HEALTH ORGANIZATION. 2000. The World Health Report 2000: Health Systems. Geneva: WHO